NTIS # PB 88-240320

NATIONAL HOSPITALS
PROSPECTIVE PAYMENT EVALUATION

CASE STUDY SITE REPORT
ALBUQUERQUE, NEW MEXICO

October 27 - 31, 1986

Team Members

Jerry Cromwell
Martin Gaynor
Judith Williams
Brooke Harrow

REPORTS
RA
971
.32
N385
1986
[no.5]

This research was supported by Contract No. 500-85-0015 Work Assignment No. 10: Case Studies of the Impact of the PPS from the Health Care Financing Administration. The views and opinions expressed in this report are the contractors' and no endorsement by HCFA or DHHS is intended or should be inferred.

Abt Associates Inc. 55 Wheeler Street, Cambridge, Massachusetts 02138 TELEPHONE (617) 492-7100
Health Economics Research, Inc. 75 Second Avenue, Suite 100, Needham, Massachusetts 02194 TELEPHONE (617) 444-8910

RA
971.32
.N385
1986
[no.5]

TABLE OF CONTENTS

		PAGE
1.0	**OVERVIEW OF ALBUQUERQUE, NEW MEXICO**	1
2.0	**SCOPE OF INTERVIEWS**	3
3.0	**HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS**	5
	3.1 Competitive Market Structure	5
	3.2 Hospital Performance	6
	3.3 Competitive Processes	7
	3.3.1 Price Competition	7
	3.3.2 Cost Competition	8
	3.3.3 Nonprice Competition	11
	3.4 DRG Monitoring	12
	3.5 CEO/CFO Reactions to PPS	13
4.0	**PPS AND ALTERNATIVE HEALTH PLANS**	16
	4.1 Structure of the Local Industry	16
	4.2 HMO Competition	16
	4.3 HMOs, PPS, and Hospital Contracting	17
	4.4 PPS Impacts on HMO's Cost Advantage	18
	4.5 Contracting with Physicians	18
	4.6 Utilization Review	19
	4.7 Medicare Enrollment and Contracting	19
5.0	**MEDICAL PRACTICE PATTERNS UNDER PPS**	21
	5.1 Site Background	21
	5.2 Overall Assessment	21
	5.3 Length-of-Stay Monitoring	22
	5.4 Admission Controls	23
	5.5 Specialization	23
	5.6 Outcomes	24
	5.7 Comments on PPS	24
6.0	**THE POST-HOSPITAL HEALTHCARE INDUSTRY UNDER PPS**	26
	6.1 Industry Structure	26
	6.2 Hospital Admissions and Discharges	27
	6.3 Hospital Discharge Planning	27
	6.4 Home Health Agencies	29
	6.4.1 Adaptations	30
	6.4.2 Patient Care Problems	31
	6.4.3 Administrative Problems	31
	6.5 Nursing Homes	31

TABLE OF CONTENTS (Continued)

		PAGE
7.0	**PROGRAM OPERATIONS**	**34**
7.1	Peer Review Organization (PRO)	34
7.1.1	Administration and Organization	34
7.1.2	Review Process	34
7.1.3	Changes Since PPS	35
7.1.4	Provider Interaction	36
7.2	Fiscal Intermediary	36
7.2.1	Claims Processing	36
7.2.2	Review Process	37
7.2.3	Relations with Providers	37
7.2.4	CPEP and PIP	38
7.2.5	HCFA Relations	38

PREFACE

This is one of ten site reports of case studies conducted between September and December, 1986, by staff members of Abt Associates, Inc. and Health Economics Research, Inc. under Contract No. 500-85-0015 to the Health Care Financing Administration (HCFA). The views expressed are our own and no endorsement by HCFA or the Department of Health and Human Services is intended or should be inferred. Each report is a summary of the facts and subjective comments from all participants at one of the ten sites.

This report characterizes the structures of parts of the health care industry (e.g., hospitals, nursing homes, home health agencies) in this site as they were perceived by members of the study team. Individual respondents and institutions are not mentioned by name, nor are they meant to be identifiable. We are interested in generalizing about the responses of the industry to the Medicare prospective payment system, not in pointing out any one type of response. We would like to raise the appropriate policy issues objectively and from all points of view. These issues can then be addressed in the statistical analyses of data on beneficiaries and providers, which in turn will be synthesized by HCFA staff into the Congressionally-mandated report about the impacts of the prospective payment system.

The ten site reports will not make up the report to Congress. The ten sites are not a scientifically representative sample of the nation's health care providers. Therefore, they are only illustrative of what is happening across the country. As such, they have already proven to be invaluable to the study staffs. The information and subjective opinions of the 500-600 respondents will be incorporated in the analyses of secondary data in five topic areas: hospital competition, alternative health plans, medical practice patterns, post-hospital care, and program operations. They are being used in developing hypotheses, exploring unexpected results and raising policy concerns.

We once again thank those many respondents who so generously gave us their time for the discussions that provided these insights. Special thanks are also due to the support staffs of Health Economics Research and Abt Associates for arranging the site visits and producing the reports, and to the secretaries of participating executives who coordinated the interviewing schedules in the field.

1.0 OVERVIEW OF ALBUQUERQUE, NEW MEXICO

The Albuquerque Metropolitan Statistical Area is located completely within Bernalillo County in the center of New Mexico. The city had 330,000 persons according to the 1980 census and was reported to be growing between 2 and 2.5 percent annually in the early 1980s. Since then, both demographic and economic growth seem to have slackened, although Albuquerque remains a growth area within the sunbelt region of the country. The city sits on a relatively flat plateau with easy local and interstate highway access to all local facilities.

There are eight short-term, non-Federal acute hospitals in Albuquerque, with no facilities operating in the county outside the city limits. Two hospitals report as one unit, however. In addition, there is a large (370 bed) Veterans' hospital which is not covered by Medicare's Prospective Payment System. There are also several mental health facilities and a small children's hospital. In 1982, there were slightly over 2,000 acute beds, or 5.1 beds per 1,000 population. All hospitals can be considered urban although one or two are operating on the outskirts of town. Albuquerque is universally considered to be an overbedded city, having overbuilt in expectation of strong population growth and unchanged utilization patterns. Neither assumption has proved to be true, resulting in drastic falls in occupancy rates after PPS was implemented.

Besides the nine acute facilities, there are several nursing homes and long-term-care beds are also considered to be in oversupply. At least five home health agencies operate in Albuquerque, but they vary greatly in size. Physicians are also relatively plentiful with 270 per 100,000 population in 1982.

Albuquerque must be considered one of the more active HMO cities in the country. Starting from only one large, established plan in 1984, five or six new HMOs have entered the market in just two years, resulting in a 20-25 percent overall penetration rate. Nearly all have Medicare at-risk contracts with very active competition for both Medicare and non-Medicare subscribers.

The hospital market structure is organized into a smaller set of five competitors with extensive horizontal integration. Five facilities, for example, are owned by two separate religious organizations. One large hospital is owned by the largest HMO, which was recently purchased by HCA. Thus, one hospital is proprietary today, one is the large county teaching hospital, and the rest are voluntary. Rivalry is extensive among the major competitors and a merger was imminent at the time of the case study. Hospitals were also actively seeking alternative uses of excess beds, including simply taking them out of service.

All hospitals receive the Medicare urban rate, but only one is enjoying any significant teaching or disproportionate share revenues. Two new facilities started on Federal payment rates and are receiving large Medicare capital passthroughs.

While most respondents feel that physician practice styles were relatively judicious in their use of inpatient services, post-PPS inpatient days have fallen considerably (15-35 percent). This has left

hospitals with 50 percent or more of their beds unused--particularly in the newer facilities. HMOs have also contributed materially to these changing patterns. Apparently, there were still significant opportunities both for avoiding admissions and shortening stays.

As elsewhere, PPS (along with HMOs) has enhanced hospitals' discharge planning function immensely. It has also encouraged them to open or purchase their own home health agencies, nursing homes, and HMOs. This has certainly facilitated the observed changes in inpatient use. Hospitals have also been converting inpatient space to outpatient surgery and other services.

Particularly impressive is the amount of high tech care being provided in the home. As might be expected, this has created problems for patients as well as providers. What is covered by Medicare in the home continues to be negotiated among providers and the FI. Also, lack of financial coverage for basic home support places a financial burden on some elderly patients.

Albuquerque, more than most cities, seems to be undergoing real "growing pains" in responding to the new payment incentives and HMO mandates. New outpatient services are growing, but with the usual kinds of administrative hassles and resource limitations. Hospitals are highly competitive for patients, a fact that is compounded by the rapid growth in HMOs. While most hospitals are in good financial shape, a few are highly dependent on "parent" facilities, infusions of outside capital, or the Medicare capital passthrough. Given the extensive overbedding in the area, which is no longer being covered on a cost basis, increasing concentration of beds and services seems inevitable.

2.0 SCOPE OF INTERVIEWS

The Albuquerque site visit was conducted with a series of interviews both inside and outside hospitals. Seven short-term general non-Federal hospitals in the city of Albuquerque participated. One hospital has an operational bedsize of less than 50 beds, although it is licensed for twice as many; one is about 120 beds; two are about 200 beds; two more have nearly 300 beds; and the largest hospital has almost 500 licensed beds. Three of the hospitals have a teaching affiliation.

A total of 44 people were interviewed over a five day period (See Table 1). Seven Chief Executive Officers, four Chief Financial Officers, and one Vice-President of Operations were interviewed in the areas of competition and PPS effects on hospital performance. Five discharge planners were questioned about early discharges and the aftercare industry. Inpatient utilization and patient management were discussed with four Medical Directors, one chief of staff, and six U/R coordinators. Outside the hospital, three additional physicians were interviewed regarding utilization and patient management: two orthopedists and one pulmonary disease specialist. All three are admitting physicians in at least one of the seven hospitals. Interviews were also held with two HMOs directors and their staffs and with one HMO contract manager of a large hospital.

Interviews were conducted with professionals in the aftercare industry both inside and outside hospitals. In addition to the five discharge planners interviewed in the seven hospitals, six outside interviews were conducted with three nursing home administrators and their staffs as well as three home health agency administrators.

Interviews covering Medicare program operations were conducted at the Fiscal Intermediary (FI) and the Peer Review Organization (PRO) for New Mexico. One day was spent at the PRO interviewing the Chief Operating Officer and the Medical Director. Another day was spent interviewing the Vice President of Government Programs, the Manager of Utilization and Medical Review, and the Director of Audits and Reimbursement all of whom work for the Medicare Fiscal Intermediary.

TABLE 1

ALBUQUERQUE, NEW MEXICO SITE VISIT INTERVIEWS BY TOPIC AREA

	Competition	Utilization and Patient Management	Aftercare Industry	Program Operations
CEOs	7			
CFOs	4			
V.P. of Operations	1			
U/R Coordinator		6		
Medical Director		4		
Chief of Staff		1		
Orthopedists		2		
Pulmonary Disease Specialist		1		
Discharge Planners			5	
New Mexico PRO				2
Fiscal Intermediary				3
Nursing Home Administrators			3	
Home Health Agency Administrators			3	
HMO Directors and Staff	2			
Total Number of Interviews	14	14	11	5

3.0 HOSPITAL MARKET STRUCTURE AND RESPONSES TO PPS

3.1 Competitive Market Structure

The Albuquerque SMSA comprises the city of Albuquerque and the very sparsely populated environs of Bernalillo County. Eight short-term general acute care facilities operate within the city limits, not counting the large Veterans hospital, the children's facility, and several mental health institutions. The eight are organized into four major competitors, but the fourth (an osteopathic hospital) was entertaining a merger offer with another multi-facility group at the time of our visit. The remaining "big three" competitors are two religious associations, one with three Albuquerque hospitals and a second with two facilities, a large (65,000 member) HMO with its own hospital, and the county teaching hospital. Three facilities have over 300 beds (ignoring recent conversions) while the rest are licensed for 100-120 beds. Two facilities opened in 1984, bringing the total inpatient beds in the county to over 2,000, or over 5 per 1,000 population. The competitors form an oligopolistic market structure of large, well-established providers. All hospitals can be considered urban facilities, although only four are providing tertiary care.

All hospitals are nonprofit except for the large HMO-controlled hospital which was bought out (80 percent) by HCA in 1985. One other hospital is managed by HCA while another five operate as part of two non-profit multi-hospital religious chains, one Catholic, one Protestant. The county teaching facility is the only one receiving local tax subsidies.

The City of Albuquerque grew relatively fast (2.5 percent population increases annually) during the late 1970s until the 1981 recession. Slower economic and demographic growth, coupled with drastic changes in the use of acute facilities have left the area grossly overbedded. Occupancy rates in most facilities have fallen dramatically, necessitating bed conversions of varying kinds, e.g., substance abuse or rehab units. The incidence of overbedding has fallen primarily on the newer facilities, built in "growth" sections of town, where occupancy rates are averaging 20-30 percent.

The organization operating three hospitals in Albuquerque is generally recognized as the area's leader in terms of prices and services, attributable in part to its overall size and pre-eminence in the cardiac field. (It also manages ten other facilities statewide.) The large HMO hospital presents unusual competition in that rivalry takes place first and foremost for subscribers and only secondarily in terms of patients. Once subscribers sign with the HMO, their choice of hospital is determined (with the minor exception of very specialized services). The county hospital, although the only major teaching hospital in the community, is considered a passive competitor at best, with its own medical staff and large indigent caseload.

Situated in a growing area with a younger population, Albuquerque hospitals are naturally less dependent on Medicare. Between 30-35 percent of their revenues come from Medicare, with the county hospital a

notable exception at 15 percent. Medicaid provides 6-12 percent of revenues while Blue Cross ranges from 5-20 percent. The remaining revenue sources are HMOs and commercial insurers. Both Medicaid and Blue Cross pay hospitals on a flat hospital-specific rate per discharge, with the hospital-specific base year adjusted annually for changes in DRG casemix and inflation.

At least six HMOs are currently active in Albuquerque, starting from just one very large group model HMO with 50,000 enrollees in 1984. HMO penetration now exceeds 20 percent and most are actively negotiating special discounts and exclusive arrangements with hospitals. Because the dominant HMO owns its own hospital, competitive pressures are brought to bear at the level of the insurer more than the patient level. Two major hospital competitors have responded to this competition by forming a joint HMO. All hospitals are taking the HMO growth very seriously, and ascribe a fair amount of the declining inpatient use to them.

All Albuquerque hospitals receive the PPS urban rate, but only one receives any substantial add-on for indirect medical education (IME) or disproportionate share (DS). Medicare casemix complexity has risen 10-25 percent in most hospitals although it appears to have fallen in a couple of facilities for unknown reasons--possibly through the triaging of sicker patients within a multi-hospital chain. The two new facilities that opened in the first year of PPS had no hospital-specific portion and began receiving the fully Federal rate from the beginning. Both also receive large capital pass-throughs.

3.2 Hospital Performance

Admissions are down 10-20 percent since the start of PPS at practically all of the established facilities in Albuquerque although, for a couple, admissions have been stable. This is somewhat misleading, however, in that two new facilities, which opened since PPS began have syphoned off patients from existing institutions. Because they are new facilities within a multi-hospital organization, the net effect of the decline on the entire organization was not as great.

Lengths of stay are also down 5-20 percent, producing a combined decline in inpatient days of 15-35 percent per facility, but again some of this is attributable to the opening of the new hospitals. Consequently, hospital occupancy rates have plummeted for most established institutions--the county teaching facility is a notable exception--while the two new hospitals are averaging 20-30 percent occupancy at best.

The hospital industry in Albuquerque entered the 1980s with high expectations of continued economic and demographic growth that did not materialize. Several hundred new acute beds were added to the stock (not counting hundreds more added in psychiatric facilities) at a time when use rates were already slowing. Then PPS and a flourishing HMO industry radically changed inpatient use patterns in just two years, leaving nearly 1,000 unused beds in the city.

Gross overbuilding accompanied by a radical restructuring of inpatient use should lead to a financially depressed industry, but such

is not the case. The four major competitors all have had positive total margins generally in excess of 5 percent, nor is there any strong evidence of a financial depression due to falling volumes at the start of PPS. If anything, rising profits accompanied declining utilization. Most of the financial burden of overbedding apparently has fallen on the two new facilities and the osteopathic institution. Both new hospitals, as part of local multi-hospital groups, have generated large financial drains on their parent institutions (annual losses well over 20 percent) but each parent organization remains profitable nonetheless. The osteopathic hospital had been having utilization and financial problems before PPS was implemented, necessitating an HCA management contract in 1980. Heightened competition for patients and a reticence of staff physicians to change their inpatient practice patterns put the hospital at a distinct disadvantage in a post-PPS world. PPS, however, does not seem to have exacerbated the problem, given the significant reduction in Medicare discounts after the program began.

While overbedding in conjunction with rapidly falling inpatient utilization explains most of the depressed performance among a few hospitals, sources of gains are more varied. First, a couple of hospitals, including the large HMO-controlled facility, have not shared in the volume declines to any great extent. Moreover, the HMO hospital has more than offset any inpatient losses through subscriber growth. Indeed, less Medicare inpatient use means a more, not less, profitable organization. Second, the county teaching facility has also been aided by a 25 percent increase in its PPS base rate to cover indirect medical education and disproportionate share expenses. No other hospital received any significant additional benefit from these or other special adjustments. The one other major source of gain has been the 20-25 percent rise in the Medicare casemix index for several of the larger hospitals. Losses on the new facilities have even been covered in part by the Medicare capital pass-through.

Were all eight of the acute facilities in Albuquerque operating independently, it is possible that at least one or two would have closed or merged with more successful organizations. As it is, the future of several facilities, if not organizations, is clouded with uncertainty regarding population growth in new areas of the city and what Congress eventually decides to do about prospective capital payment.

3.3 Competitive Processes

Hospitals compete in three ways. The first is through lower prices, or at least lower rates of increase, that attract patients. The second is through management improvements that lower costs for a fixed price schedule. Third, hospitals can engage in various forms of nonprice competition.

3.3.1 Price Competition

Hospital financial officers universally agree that "charges make no difference" when it comes to competing for patients in Albuquerque. Essentially all hospitals have been raising room rates and ancillary

prices 4-10 percent yearly, in spite of large admission declines. Moreover, there is some indication that the institutions suffering the most from volume declines have been raising charges faster to cover rising fixed costs.

Charge schedules, however, do not accurately reflect true discounted prices for many reasons. First, about 20 percent of Albuquerque's population (about 70-80,000) belong to HMOs and the number is growing rapidly.* Several HMOs have been able to take advantage of the overbedding to negotiate deep discounts in a few hospitals. Furthermore, both Blue Cross and Medicaid, which together make up roughly 20 percent of the market, pay on a flat rate per discharge basis, using DRGs as an end-period casemix adjustor. CFOs feel that both these payors are quite fair, implying insignificant discounts. With another 30-35 percent of revenues based on a fixed Medicare payment per DRG, well over half of the industry's revenue is unrelated to charges in the final analysis. Commercial insurers are a significant part of the remainder, and they generally pay billed charges. While PPOs are growing in Albuquerque, it would appear that commercial insurers are bearing the major part of any price increases.

Hence, as in many hospital markets, little overt price competition is taking place in Albuquerque. The eight hospitals are horizontally integrated into just five competing systems, with one of the five reportedly planning to merge with another competitor shortly. The county teaching hospital plays a passive role for the most part, further enforcing the impression of a highly concentrated market. An oligopolistic pricing structure ensues with room rates generally within a few dollars of each other, at least among the major competitors. There is an established price leader in the community based on size and the earliest start date for the fiscal year. While one hospital pursues quite independent pricing policies, it does so to maximize revenues, not to attract patients.

3.3.2 Cost Competition

Significant overbedding, resulting in part from declining inpatient use, has raised fixed costs per case and put Albuquerque hospitals in general under pressure to reduce costs. While cost per case was not unusually high at the program's beginning, particularly relative to the nation, falling volumes have encouraged hospitals to adopt innovative cost strategies. Almost all have experienced significant declines in Medicare lengths of stay, necessitating further reductions in inpatient services--especially nursing. Different competitive positions, however, have dictated different cost strategies.

---

*This figure overstates HMO leverage on hospital prices, however, as three-quarters are enrolled in a single large group plan with its own hospital.

Cost management efforts can be categorized into five areas:

(1) Structural;
(2) Labor costs;
(3) Non-labor costs;
(4) Utilization controls;
(5) Organizational.

As might be expected, many Albuquerque hospitals have made structural changes to more effectively use expensive beds and facilities--more so than in other, less overbedded, areas of the country. First, all but one hospital have taken beds out of service, resulting in several hundred fewer beds community-wide. Bed conversions to other uses such as rehab, monitoring units, dialysis, outpatient surgery, and office space have also taken place. One hospital was setting up a hotel-hospital concept by converting an entire floor of the hospital to rooms for visiting families. Another, new, hospital opened with all private rooms while charging a semi-private room rate. Still another redesigned its nursing units from 40 to 36 beds with a nursing substation to improve efficiency and patient management. Lack of volume forced one hospital to close down operating room suites, although the opposite was true for at least one other facility, which was trying to improve its service offerings to attract more patients. Pediatric and med/surg beds have been intermingled. Capital expansion forecasts have generally been curtailed. An important exception is the major HCA-funded building program at the HMO-controlled hospital, which is in part a response to the huge new renovation and building programs carried out by rival hospitals prior to PPS.

Concomitant with declining use are cutbacks in employment in Albuquerque amounting to several hundred workers over the last few years. Most reductions have been accomplished through attrition, but layoffs have also been necessary in some hospitals. One hospital has a new wage program that guarantees only 80 percent of a person's salary; if census is down, this gives the hospital the flexibility to cut back on FTEs, almost at will. Automatic cost of living adjustments are now uncommon in Albuquerque with more emphasis on paying what the market demands and no more. Merit raises are no longer automatic either. With the general decline in volumes, hospital workers have not been in a strong negotiating position. Some wages were frozen the first year of PPS, with just 2-3 percent annual increases thereafter.

The substitution of RNs for LPNs continues apace, with recruiting as far away as Nebraska. One or two hospitals note the adoption of nurse acuity systems to better schedule nursing needs and raise productivity.

In non-labor areas, hospitals are computerizing nurse scheduling, inventories, pharmacies, patient diets, OR schedules, patient care information systems, and the like. All have group purchasing, either directly or through an HCA contract.

In the area of utilization, several innovative changes have occurred. In one hospital, a total parenteral nutrition program has been implemented at a surgeon's request, in order to shorten stays.

Pharmacists in the same hospital now have the authority to change a physician's request to a less expensive, but equivalent, drug. Another hospital has introduced a continuity of care program that follows the patient from pre-admission through discharge, planning the sequence of tests and length of stay. It has also set up a complementary mobile admission service to take patient histories, blood and ECG exams, etc., prior to admission. The OR schedule is more tightly controlled everywhere as well as shifting more surgery to an outpatient setting. Another administrator sees a change in budgeting philosophy. Whereas in the past budgeting focused solely on the department, now administration concentrates on intensity per case. This, he believes is a much more productive way to manage departments.

Finally, several organizational changes are worth noting. One association with three facilities was completely reorganized last summer (1986) to encourage interfacility cooperation instead of competition. Instead of making each administrator responsible for the facility's "bottom line," each is now responsible for specific functional areas across the three facilities. All outpatient care is concentrated in one facility, for example.

Even more innovative is the elimination of the nursing department and its subordination to "program directors." These directors are responsible for major clinical departments like heart, medicine, and obstetrics, with all nurses and other staff reporting to each director. This serves the dual purposes of (a) focusing the hospital's resources on treating particular illnesses efficiently, and (b) developing an effective marketing tool. Medical care teams of physicians and staff now think of treating patients with related illnesses and are more involved in marketing their services to the larger community.

In spite of these innovations, probably the biggest organizational changes in Albuquerque are yet to come. HCA has bought out the largest HMO and made it a for-profit venture. This is certain to change the operation of the hospital, starting with the huge new building program, and result in more aggressive HMO marketing. Also, the osteopathic hospital has seriously entertained a merger offer from a rival hospital organization. Should a full merger occur, the city would have one less competitor and a better matched set of rivals overall.

In any event, multi-facility groups now almost completely dominate the Albuquerque market, enjoying one special advantage; namely, the spreading of fixed management and financial resources over more patients. Such consolidation has been the natural result of competition elsewhere in the economy, and similar trends are evident for hospitals. If anything, PPS and HMOs may give larger, centrally managed institutions special advantages in the hospital market. They can afford the complex patient management information systems, raise capital more easily, adopt new services, and negotiate with HMOs and other insurers from a strengthened position. Finally, smaller institutions no longer have the ability to pass the costs of scale diseconomies along to third party payers like Medicare.

3.3.3 Non-price Competition

With a small number of large multi-facility competitors and little out-of-pocket expenses incurred by patients, price competition plays a minor role in hospitals' competitive strategies. The burgeoning HMO movement in Albuquerque clearly is putting more and more emphasis on price, but the primary rivalry remains in the areas of new services, specialists, primary care networks, and promotion.

Most Albuquerque hospitals are in large, tertiary systems with a high level of service competition. One system is pre-eminent in cardiac surgery (including heart transplants), which adds materially to its leadership role; a fact that is recognized by other competitors. Oncology, rehabilitation, obstetrics, orthopedics, and osteopathic care form "centers of excellence" among competing institutions. Administrators are chary in speaking of their expansion plans, which is indicative of the heightened service rivalry in a post-PPS world. Taking on a major provider in an established area like obstetrics or heart surgery involves major human and capital investment at a time when hospitals are under increasing financial risk. Yet, several are looking for opportunities to expand, if for no other reason than to assure their long-run survival.

Smaller facilities are also trying to find a competitive niche, offering respite care for elderly caregivers, a pediatric infirmary for working mothers, 24-hour emergency rooms, alcohol abuse centers for problem on-the-job drinkers, all private rooms, inter alia. While the large tertiary facilities project "cool professionalism" and "aggressive treatment" of major illnesses, smaller facilities are promoting a primary care, personal image.

Most Albuquerque hospitals are well endowed with specialists, yet medical staffs are sharply segmented across institutions, i.e., the teaching staff at the university hospital, the salaried staff at the HMO-controlled hospital, the osteopaths at their facility. Two other principal competitors share medical staffs, which makes them more competitive than usual for admissions. On another level, however, these two hospitals and their common staffs compete as a whole for patients in the greater Albuquerque area with other hospitals--most notably the HMO group.

Heightened competition for HMO subscribers has led to two interesting developments. First, the large HMO has always had several off-site clinics throughout the city. This has prompted other hospitals to open similar clinics and emergicenters now that admissions are the primary basis of payment for Medicare, Medicaid, Blue Cross, and the other HMOs. Second, the two rivals sharing a common staff have started their own HMO to "lock in" patients and avoid further leakage to the dominant HMO. New HMOs have also been using their market leverage to sign exclusive contracts with underutilized hospitals.

Hospitals until recently have not actively advertised through the various media, but that has changed. Once one hospital began a campaign, however, a few others felt they had to respond with campaigns of their own. Advertising is still constrained, though. The segmented nature of

the physician market with teaching physicians in one hospital, HMO physicians in another, etc., limits the effectiveness of any promotional effort to attract patients. Some administrators also feel it is inappropriate to engage in advertising while others are not permitted to advertise by their charter. HMOs, possibly more than hospitals, have undertaken promotional efforts, with an emphasis on the advantages of managed care, no out-of-pocket payments, and continuity of care.

Most hospitals have implemented guest relations programs and one has hired a full-time patient advocate. Improving amenities, better diets and menus, and refurbishing the facility are all common promotional activities.

3.4 DRG Monitoring

As elsewhere, administrators on the eve of PPS were quite ignorant of the cost differences among patients in their institutions. Cost reimbursement placed no value on such knowledge. This changed within a few months, as hospitals purchased or designed their own DRG software and started producing DRG management reports. Physicians were educated on PPS incentives in general meetings and special committees were established to investigate problem DRGs like chemotherapy, COPD and pneumonia. Most doctors responded quickly by shortening stays and shifting as much care as possible to an outpatient setting. Hospitals where physicians were not responsive eventually suffered the most, financially.

While most of the PPS effect on practice patterns appears to have come from the program's broader incentives, administrators report several concrete examples of DRG management. Most have carried out special DRG studies, tracking problem DRGs and physicians. Outliers have been a principal focus in some hospitals, easily identifiable to administrators for the first time. Outmoded, underutilized services have been re-evaluated with more rigorous payback analyses conducted before purchasing new equipment. Sequencing tests from pre-admission through discharge to shorten stays has also been formally mandated in one institution. Another hospital had been admitting surgical patients for testing the night before an operation because it lacked the space to do tests on an ambulatory basis. It has since expanded its outpatient testing area and eliminated the pre-operative day. Pharmaceuticals have been re-evaluated in many places and less expensive drugs substituted where medically feasible. One hospital set up an "unbundling" committee to shift as much testing and surgery to an outpatient basis as possible. Another hospital even sent two administrators to New Jersey to learn how to manage under PPS.

It is not clear whether DRG management continues to grow or has peaked. After a flurry of activity, most administrators have become frustrated at the lack of specificity in their DRG reports and the difficulty of separating fixed from variable costs. They recognize losing DRGs but often have to learn to accept and manage them if they are to remain a competitive, full service hospital. Many directors mention DRGs as serving useful purposes in directing their marketing efforts and

negotiating HMO and other contracts with outside insurers. The underlying management advantage to paying on DRGs is probably the sentinel effect; physicians know these review committees exist, and occasionally they find ways of practicing in a less costly fashion without being explicitly told. This would be a weak reed to rely on by itself, but when backed by the underlying PPS incentives to reduce intensity per admission, DRG management provides some mechanism for focusing hospital and physician efforts.

3.5 CEO/CFO Reactions to PPS

Update Factor

"Too much ratcheting down on the update factor."

"Let society forgo another aircraft carrier this year and concentrate on healthcare."

DRGs

"Recalibration of DRGs obviously budget driven. Little clinical basis for recalibrations. Should look at need first, not dollars."

"DRGs are the way to get reform in a hurry."

"Oncology DRGs priced too low, especially radiotherapy and chemotherapy."

"If HCFA gets fancy with DRGs on severity, hospitals will have trouble keeping up with the necessary information system."

"Many DRGs are subsidized by other payers."

"DRGs don't represent costs. Not scientifically determined."

"People who put DRGs together couldn't have had right database; they led to illogical results and national losers like cataract surgery."

"Need to set up substance abuse DRGs with appropriate level of inpatient and outpatient use."

Outliers

"Without ability to recapture legitimate outlier costs, in ten years we will not have a viable system."

"Small rural hospitals getting hit hard by outliers; large hospitals insulated."

Capital Pass-through

"Capital pass-through will destroy small hospital."

"If capital payment proves inadequate, hospital infrastructure will fall into disrepair leading to a new Hill-Burton program."

"No clear fit with individual DRGs and capital costs."

Physicians

"Hospitals and physicians are not on a level playing field for outpatient care. Physician is not burdened with institutional requirements; can build cath lab without regulations."

"PPS not necessarily bad for patients, as physicians are not good at managing public trust and monitoring excess utilization."

"Our physicians would not have changed their practice patterns without PPS. There are no more social admissions."

General Criticisms

"Retrospective reimbursement was kind of nice; didn't have to manage as efficiently and government bore all the risk."

"Shouldn't put hospital administrator in the position of the bad guy in the system; can't make hospital the conscience of society."

"Need to eliminate cost audits and streamline reporting."

"Too much uncertainty on regulations, updates, recalibrations. Need to give administrators constant, uniform set of instructions."

"PPS won't last because government will eventually publish a fee schedule and turn hospital industry into a public utility."

"PPS was government intrusion that has limited independence of hospital and physicians more than anything else; crude, meddlesome regulations."

"HCFA should set national charge schedule and pay on a per service basis."

"Government not concerned over quality of care; they're blowing smoke."

Positive Aspects of PPS

"Made us more cost conscious, made us automate, and take responsibility for the productivity of our employees."

"Hospital would have been worse off financially. Now we get to keep every dollar we save."

"Retrospective reimbursement difficult; now hospital has a consistent cash flow and no big year-end settlements."

"No problems with quality; no catastrophic outcomes."

"PPS brought a level of sophistication to resource management. Before this, administrators and staff didn't care because they had an unchallenged tap into the Federal Treasury."

PRO/FI

"Real coding difficulties with PRO. They have been wrong in some cases."

"Government never meant PSROs to work. It always wanted to control medicine."

4.0 PPS AND ALTERNATIVE HEALTH PLANS

4.1 Structure of the Local Industry

Prior to 1985 Albuquerque had only one HMO; now it has at least six and possibly more. One nationally recognized health plan was founded in 1973 as a loose-knit physician-run IPA that continually had problems controlling utilization. Then in 1980 it became Federally qualified, reorganized into a group HMO, and expanded rapidly to 50,000 enrollees by 1984, mostly in the Albuquerque area. Beginning in early 1985, several national HMO networks began to enter the market. Blue Cross-Blue Shield also implemented an HMO statewide and two Albuquerque hospitals formed their own HMO to reduce patient leakage to the large group plan.

Presently, roughly 80,000 persons living in Albuquerque are enrolled in HMOs,* which is equivalent to a 20-25 percent penetration rate. Five year projections of HMOs have Albuquerque with a 40 percent penetration rate, although this seems on the optimistic side. This would make Albuquerque one of the most HMO-dominated markets outside of the large west coast cities. Several HMOs also have Medicare at-risk contracts ranging from 500 to 5,000 enrollees. Twelve thousand out of 50,000 elderly are already enrolled. Hence, Albuquerque HMOs form a significant experimental group for evaluating Medicare at-risk contracting.

Interviews were conducted in two of the plans that together account for at least four-fifths of all areawide enrollees. Every hospital CFO who participated in the case study was also asked several questions about the role HMOs play in the greater Albuquerque area and, more specifically, what impact they are having on discounts, utilization, and competition in their own institution. From these interviews, we were able to construct a broader picture of the structure and rivalry among HMOs in the market and form some opinions as to how PPS and HMOs, together, were affecting hospital behavior and performance.

Most of the HMOs are IPAs, but the dominant HMO is based on a salaried panel of physicians. This group also makes (nearly) exclusive use of its own hospital.

4.2 HMO Competition

Competition among HMOs in Albuquerque is very skewed by the existence of the large group HMO of long standing in the community. This HMO owns its own hospital, which allows it to control utilization and costs more directly. As a result, at least two-thirds of the HMO enrollees in the city are locked-in to one hospital and cannot be used as leverage in negotiating discounts or shifting risk to other hospitals. The presence of one large own-hospital HMO does, however, put downward pressure on physician inpatient use throughout the community (albeit not

*This is a very rough estimate as nearly all HMOs only report statewide enrollment figures.

strong pressure) and encourages other hospitals to set up their own HMOs in retaliation.

Even though one plan dominates the market and sets a standard for benefits and premiums that other HMOs must be sensitive to, there seems to be room for HMO growth. There is concentration of major U.S. companies in Albuquerque which makes marketing easier and the community seems fairly open to the managed care concept. Also, the fact that the large HMO is a closed group practicing at a single hospital provides an opportunity for IPAs to market on a "freedom of choice" basis.

It is quite likely that Albuquerque can support 5-6 HMOs--particularly if they are also marketing statewide. Most will likely grow over the next few years, particularly if one or two decide to leave the market.

4.3 HMOs, PPS, and Hospital Contracting

In explaining the nature of HMO contracting with hospitals it is important to remember that (a) Albuquerque is a very overbedded market, and (b) physicians are locked-in to specific hospitals. Overbedding should give HMOs more negotiating leverage while the highly segmented physician market restricts MDs' ability to shift enrollees from one hospital to another.

As more and more beds have been freed up by the 20-25 percent decline in inpatient days, HMOs have moved aggressively to take advantage of the situation. The large HMO, of course, had always negotiated a capitated rate for its inpatient services, but now the newer IPAs are doing likewise. Contracting has evolved very quickly from paying billed charges, to discounted charges, to per diems, to discounted per diems, and finally a capitated rate for all inpatient care. Most HMOs now pay hospitals on a discounted per diem basis, putting the hospital at risk for intensity increases while the HMO remains at risk for longer stays. In a couple of instances, they have gone so far on their Medicare at-risk enrollees to negotiate an exclusive, capitated rate for all inpatient care per beneficiary per year. That hospitals would consider entering such a risky contract is a good indication of the overbedding in the area. Several hospital CFOs definitely recognize the cost implications of greater volume and feel that taking on more risk is worth the low marginal costs that would be incurred.

Medicare DRGs play a key role in several HMO payment methods or casemix adjustors. Both Blue Cross's HMO and the joint-hospital-initiated HMO have used DRGs to establish per admission payment rates. The large HMO is also trying to negotiate DRG rates per admission with other hospitals for specialized services instead of paying billed charges. HMOs with Medicare at-risk enrollees also have the option of paying the going DRG rates with hospitals unless they can negotiate a discount. Per admission contracts have the effect of shifting the risk of both intensity and length of stay onto hospitals, with the HMO concentrating only on necessity for admission and post-hospital care.

4.4 PPS Impacts on HMOs' Cost Advantage

Probably the biggest PPS spillover to HMOs is the growing familiarity of hospitals with the costliness of individual illnesses. All institutions now have DRG reporting systems that allow them to price specific illnesses. This is critical in negotiating HMO rates, either per diems, per discharge, or per capita. While HMOs generally do not pay on DRG rates (they think they are too crude or not accurate cost-wise), they can talk specifics with hospitals about their DRG casemix versus the expected casemix from a panel of enrollees with a given age-sex distribution. Hospitals also feel more confident in taking on more risk now that they are more certain about their casemix and how it varies over time.

A second advantage of PPS to HMOs has been the upgrading of inpatient utilization review. PPS has forced hospitals to closely monitor intensity and lengths of stay, which reinforces any inpatient UR done by the HMO itself. This is particularly valuable to the smaller HMO that lacks the resources to do extensive concurrent review in the hospital. HMOs have also noted the accelerated trend toward outpatient surgery and diagnostic testing which, again, is consistent with their utilization objectives.

As to the effect PPS has had on their cost advantage, there is no evidence that a less expensive fee-for-service sector is slowing the growth of HMOs in Albuquerque. Overbedding and rapidly rising average fixed costs have resulted in rising charges to commercial payers and continued interest in HMOs. Blue Cross has put in its own TEFRA-like hospital payment plan that reinforces PPS incentives and presumably constrains its own premiums. The projected growth in HMOs by almost everyone interviewed is further indication of the competitive advantage they maintain over fee-for-service medicine.

4.5 Contracting with Physicians

Two generic modes of HMO physician contracting exist in Albuquerque. The large group panel HMO pays its physicians a salary based on previous years' total practice revenues with a very large withhold. If the entire plan does well, physicians receive salary bonuses at year end. Because of the diffuse incentives that this arrangement has to control costs, the HMO hospital is planning to introduce physician-specific capitation arrangements next year. The HMO has also upgraded its UR function to monitor unnecessary services and admissions more closely.

Most of the other IPAs pay physicians on a fee-for-service basis also with a holdback. In one plan, physicians share 50/50 in the hospital gains or losses while on primary care they are capitated with a 20 percent withhold. Again, because physicians do not seem to be responding well to financial incentives to control utilization, the plan has introduced pre-admission authorization and upgraded its own UR.

4.6 Utilization Review

Over the years the large group HMO with salaried physicians has developed stronger utilization controls to supplement the basic financial incentives to control costs. It is now doing concurrent review of all hospitalized patients. Formerly this was done by hospital nurses for non-HMO patients, but recently the HMO has taken over all UR in the facility to reduce costs. "Medical back" admissions continue to be a problem because of the lack of good admissions criteria, nor does the HMO have standardized protocols for high cost patients. With increasing financial pressures from PPS plus other HMO competition, the group HMO, by its own admission, is having to improve its UR function and rely less on intrinsic financial incentives.

Other HMOs that were relying on primary care gatekeepers are rapidly supplementing the weak financial incentives to control utilization. They are starting to use sanctions, prior authorization, and limiting the number of specialist visits per period. Where possible they are shifting inpatient utilization risk onto the hospital. This has been fairly successful. They generally have not done any hospital-specific utilization studies as yet, but some are planned. The HMO utilization directors see definite improvements in the areas of outpatient surgery and eliminating pre-operative days, but they feel that the area can do more; that the change in practice patterns, particularly admissions, has not been what it could be.

Many of the plans are still quite small and scale diseconomies work against a large, in-hospital, utilization effort. Offsetting their size limitation is the close proximity of hospitals in Albuquerque and the HMOs' ability to shift the utilization risk onto the hospital because of the overbedding.

4.7 Medicare Enrollment and Contracting

At least four Albuquerque HMOs enroll Medicare beneficiaries on an at-risk basis. According to one plan, roughly 20 percent of all Medicare eligibles are in such arrangements, giving Albuquerque one of the highest at-risk penetration rates in the country. The large HMO has been familiar with capitation in Albuquerque for a long time and its administration is quite comfortable with the AAPCC concept and competing with the fee-for-service sector. Other plans have gone through a financially painful learning process with some large losses from hospital overutilization. A few have temporarily closed their at-risk enrollment while negotiating capitated rates with hospitals, in order to shift the utilization risk of these high cost enrollees. The hospital portion of the AAPCC has been used as the actuarial benchmark in these negotiations.

With four competing at-risk plans, significant premium and benefit competition is taking place. Monthly premiums range from zero to nearly $30 (over and above Medicare AAPCC payments). The prescription drug benefit has been a two-edged sword. Smaller plans have offered it to gain a competitive advantage, but the resulting adverse selection has produced large losses. These plans are now instituting small drug copays

and capitating drugs with local pharmacies. One plan is also having potential members attend at least two meetings to learn about utilization constraints. They also must sign an attestation that they understand the limitations, to avoid misunderstandings later on. Plans also claim that the rising Medicare deductibles and copays for Part A and B services has encouraged sicker patients to join HMOs, exacerbating adverse selection.

In choosing a marketing strategy, setting premiums and copays, negotiating hospital and physician payment rates, setting benefit levels, and instituting sound utilization review, "Medicare risk contracting is not for amateurs." Any plan's Medicare at-risk group will likely generate 4-6 times as much utilization as its non-Medicare enrollees; therefore, any mistake in pricing, benefits, or utilization is correspondingly magnified and can drown an otherwise successful HMO. Experience in managing elderly care, coupled with a "hungry" hospital industry, mitigates the risk in Albuquerque--at least for some HMOs.

5.0 MEDICAL PRACTICE PATTERNS UNDER PPS

5.1 Site Background

In 1983, there were 1,044 physicians actively engaged in patient care in Bernalillo county, in which Albuquerque is located. This represents roughly half of all the active patient care physicians in the state of New Mexico. Of those physicians, 70 were in general practice (6.7%), 238 were in medical specialties (22.8%), 252 were in surgical specialties (24.1%), and 238 were in other specialties.* The physician-population ratio was equal to 2.7 physicians per 1000 population in 1982.**

The typical pattern for physicians in Albuquerque is to have admitting privileges at two or three hospitals. The largest two private hospitals share staff to a very large extent with joint admitting privileges. Many physicians at the county hospital also have admitting privileges at the Veteran's Administration hospital. The remaining two independent, private hospitals are anomalies. One is an osteopathic hospital, and the staff does the vast majority of its admitting there. The other hospital is owned by an HMO, and its physicians are encouraged to admit there insofar as is medically appropriate. Physicians at these hospitals do have admitting privileges at one or two other institutions but use the privilege less frequently than non-HMO physicians might.

The practice style in Albuquerque is conservative, both in terms of inpatient admissions and length-of-stay. There is a very strong emphasis on performing procedures on an outpatient basis. In addition, the average length-of-stay is low, due to a practice style that stresses discharging patients expeditiously. This practice style was in place well before PPS was introduced, although PPS has reinforced these trends. The length-of-stay in Albuquerque was well below the national average before the introduction of PPS.

5.2 Overall Assessment

Even though lengths-of-stay were already low and outpatient utilization already extensive, PPS did have an impact in both these areas. Outpatient utilization increases of 20-30 percent post-PPS are reported, and lengths-of-stay fell between 1 and 2 days. Respondents indicate that lengths-of-stay are still decreasing, and outpatient utilization still increasing, although the rates of change have slowed significantly.

All the hospitals instituted educational programs for physicians following the introduction of PPS. These programs informed physicians about the nature of the new reimbursement system, the new documentation

---

*Source: Physician Characteristics and Distribution in the U.S., 1984 Edition, American Medical Association, Chicago, Illinois.

**Area Resource File, 1982.

requirements, and the roles of the Peer Review Organization (PRO) and the Fiscal Intermediary (FI). These educational programs seem to have been effective, based on the large reductions in inpatient use. Most of the hospitals have supported the trend toward increased outpatient utilization by purchasing equipment, hiring support staff, and renovating existing facilities or constructing new ones. PPS incentives are reinforced here by Medicaid and private insurers, especially HMOs, which are all on per case bases of payment.

All of the respondents feel that the PRO played a large role initially before hospitals had thoroughly familiarized themselves with the new regulations and the PRO's interpretation of these regulations. At present, there are relatively few denials, and a significant part of the PRO's role consists of prior approvals.

All of the respondents have observed the following changes: sicker patients upon admission, shorter stays, more early morning admissions, more outpatient treatment where possible, patients discharged sooner, a greater focus on the medical necessity of extended stays, and fewer social admissions.

5.3 Length-of-Stay Monitoring

With the advent of PPS, Albuquerque hospitals intensified their length-of-stay monitoring efforts. This consisted of extending or intensifying pre-existing programs for utilization review. A typical response has been to extend utilization review to either 100 percent of all admissions, or 100 percent of Medicare and Medicaid admissions. One hospital did extend utilization review to pre-admission review, but no other hospital has taken that step as yet. Reviews have intensified in part due to the greater documentation required by the PRO.

The typical review process works in the following manner. Upon admission, a patient is assigned a DRG with an expected length of stay. This is typically done through the medical records department using a commercial computer software package. UR nurses review each patient's chart every day. If the physician's notes are incomplete, or if the patient is nearing expected discharge, they notify the physician. If there is disagreement between the attending physician and utilization review, a physician from the utilization review committee intercedes. According to respondents, conflicts are always resolved at this point. Formal procedures for resolving conflicts beyond this point exist, as do sanctions for physicians, but no respondent reports any incident of their use.

Utilization review does not encompass outpatient, ICU, or ancillary utilization. There are no formal review procedures for anything except inpatient utilization, but all respondents report that informal monitoring is used to control utilization.

None of the hospitals has instituted physician-specific feedback on length-of-stay or expenses. One hospital indicates winner and loser DRGs in the staff newsletter. Another amends each patient's chart with the expected and actual length of stay and expenses. No hospital sends DRG reports to its physicians. Generally the hospitals do not transmit

information about DRGs to the physicians. All the hospitals held educational programs for physicians at the onset of PPS but only as a one-time activity.

In spite of high Medicare patient shares (27%, on average), hospitals appear not to have made any serious efforts to design a practice pattern management strategy in response to PPS. The major reason for this is that they have had no financial incentive to do so. Because Albuquerque was characterized by low lengths-of-stay and frequent outpatient testing and outpatient surgery before PPS, hospitals were faced with little need to change practice patterns. Indeed, since they are well below the national average, that incentive has diminished even further as Albuquerque hospitals have moved onto the national rate.

5.4 Admission Controls

Overall, the changes in admitting practices are characterized by a shift to outpatient services, fewer social admissions, and fewer transfers to the county hospital. Albuquerque hospitals are attempting to handle as many cases on an outpatient basis as is medically advisable. This trend was in place prior to PPS, but has been accelerated by the simultaneous introduction of PPS and changes in other insurers' plans emphasizing outpatient treatment. The PRO has played a role here mainly through cases which require prior authorization. The financial incentives present in PPS and in other insurers' reimbursement plans also provides an incentive for hospitals to perform a procedure on an outpatient basis if advisable.

Social admissions have definitely declined since Medicare now does not pay for them nor do many other insurers. Hospitals have encouraged physicians to treat these patients in other ways. Support facilities and personnel for outpatient procedures have improved, although most hospitals have not required that a procedure be performed on an outpatient basis. This has not been necessary due to the need for prior approval and stringent guidelines of the PRO and other insurers.

The county hospital has tried to discourage medically unnecessary transfers of indigent patients by refusing a transfer if the patient can be treated at the transferring hospital. Otherwise, transfer patterns have not changed. None of the respondents feel that hospitals have tried to encourage or discourage certain DRGs, beyond the shift to outpatient treatment and the decline in social admissions generally.

5.5 Specialization

Physicians generally have no idea of which DRGs are winners and losers, and hospitals have not attempted to inform them about this. Physicians claim that admitting patterns have not been affected, and that hospitals have not attempted to affect the types of cases they admit. Such impressions are quite at odds with the large declines in admissions, unless respondents are implicitly ascribing all of the change to PRO and HMO review.

All the respondents indicate that transfer patterns have not changed. This seems to be the case. Dumping to the county hospital exists, but the county hospital is trying to limit its extent.

5.6 Outcomes

Respondents indicate that PPS has thus far had no impact on the quality of care, but it might have detrimental effects if the program is tightened further. If anything, it is felt that quality of care has improved due to more extensive and intensive utilization review and quality assurance.

No respondents feel that physician incomes have been affected at all by PPS.

5.7 Comments on PPS

Physicians and UR coordinators had a number of positive and negative things to say about PPS. For example,

Criticisms of PPS

"There is a potential problem with too much political pressure from sanctions from the PRO. A quota is not right."

"Because length-of-stay is so much shorter patients require more care and it is more difficult to get them into nursing homes. People who can't go home go into the nursing home and use health care."

"Regulations seem to change day to day."

"HCFA should make a common set of rules for PROs and FIs."

"When HCFA told the PRO to cut the number of bunions, strokes and cancer, it was ruling by fiat, instead of trying to improve quality of care."

"DRGs don't consider malpractice problems, an internist almost had a catastrophe due to DRGs. A patient was almost sent home, but started bleeding again. Short stays lead to catastrophes."

"Physicians are accustomed to calling the shots, not being shot at."

Positive Aspects of PPS

"Overall quality of care is better."

"Both doctors and nurses are involved more in care. They have to be more aware of what they are doing."

6.0 THE POST-HOSPITAL HEALTHCARE INDUSTRY UNDER PPS

6.1 Industry Structure

Post-hospital services in Albuquerque are more accessible than in many other areas of the country because of an abundant supply of nursing home beds. In fact, as noted earlier, the area has an excess of institutional beds of all types as a result of relaxation of Certificate of Need requirements a few years ago. Hospitals here have had less trouble than in other areas in placing patients in need of nursing home care, although facilities still try to be somewhat selective in the kinds of patients they accept.

Home health agencies appear to be able to meet the growing demand for their services, even though there are only five Medicare-certified agencies. Most of the agencies have service arrangements with hospitals and assist them in discharge planning for home care.

The post-hospital care environment appears very competitive in Albuquerque for a number of reasons. Overbedded hospitals must compete with one another to maintain their patient censuses. Further, there is extensive HMO activity, which is drawing patients away from other providers, including home health agencies. HMOs are attempting to provide their own home health care, but current capacity is limited, often necessitating arrangements with free-standing home health agencies.

A striking feature of the Albuquerque area is the prevalence of horizontal and vertical integration among providers. Vertically integrated corporations include hospitals, home health agencies, durable medical equipment companies, "high-tech" home care, and nursing homes. Through these arrangements, post-hospital care providers are reasonably assured of referral sources while hospitals can place patients quickly.

The current fiscal problems of New Mexico are expected to have a negative effect on the availability of services to low income patients. The state budget cutbacks mean fewer resources for Medicaid and other services to low income groups. This is expected to present special hardships to the "medically indigent," the percent of whom is twice the national average. Medicaid is perceived to be retrenching, particularly on community-based services; it faces an excess supply of nursing home beds, a factor which produces budget pressures that are usually beyond administrative control, as Medicaid is an entitlement program. Social services funded from Title XX of the Social Security Act are also under pressure, according to providers. These fiscal problems are expected to create problems in obtaining care in the community. These problems are expected to be exacerbated by hospitals discharging patients earlier and in need of post-hospital care. For example, many discharged Medicare patients need short-term support services for personal care and meals but are unable to afford them, and Medicare does not pay for this type of care.

Sub-acute care is not prominent in the Albuquerque hospitals we visited, although some hospitals have developed small programs or are planning larger-scale alternatives. One hospital is planning to build a hotel adjacent to the hospital in order to reduce hospital admissions the

day before surgery; the hospital will pay for the night in the hotel. The same hospital also has a few observational units to accommodate patients who may not actually be admitted to the hospital but need attention for less than 24 hours.

6.2 Hospital Admissions and Discharges

In Albuquerque, as in other areas, lengths of stay have been reduced and admissions have declined. Patients are being discharged earlier in their recuperative phases and patients who were previously being admitted for "social" reasons are not being admitted at all. This has led to an increase in both the numbers of home health patients and the types of care provided in the home. For example, now that intravenous procedures are routinely done in the home, these patients no longer stay in the hospital an extra two or three days.

Caseloads of discharge planning staffs have increased in most hospitals, as has the complexity of their patients' problems. The result has been more work and more varied tasks for discharge planners and post-hospital care providers, particularly home health agencies.

6.3 Hospital Discharge Planning

Discharge planning in the Albuquerque hospitals ranges from the traditional social service model to more innovative models with nursing and utilization review functions. In the hospitals that have changed their approach, nursing has become the dominant discipline, in order to meet the greater needs of patients. In some hospitals discharge planning has become a fairly complex, aggressive activity split between nurses and social workers. Discharge planners still feel that hospital administration and attending physicians do not make optimal use of their skills; a common complaint around the country.

Discharge planning is organized differently in each hospital, which may indicate a lack of concensus on the best model or that the function is not studied carefully and tends to evolve on its own or be molded by a particular personality. Only one hospital maintains the traditional social services model. In several hospitals social service or counseling departments have been expanded to include discharge planning. Other hospitals have gone further and combined utilization review with discharge planning. By contrast another hospital recently dissolved a previous merger of discharge planning and utilization review.

Still another hospital had taken the final step and combined discharge planning with pre-admission testing, utilization management, and an outreach program for the elderly. Only in this hospital do discharge planners aggressively go about case finding, confer with physicians on courses of care, and attempt to educate physicians and other staff on alternative loci of care. In this hospital, discharge planning had been considered a nursing function separate from social work, but now the two have been combined and together report to the operating division of the hospital. The stated reason for the merger is to make the discharge planning function a generalist one, avoiding a specific disciplinary focus.

Staffing in the discharge planning units almost always consists of nurses and social workers, assisted by a home health agency nurse. Some of the hospitals make no disciplinary distinctions between nurses and social workers but simply split caseloads between them. Other hospitals use the two in teams with each person assigned a function. In one hospital the team approach is used, with the lead person determined case by case depending on whether the primary post-hospital need is medical or financial.

The relationship between physicians and discharge planners appears strained in participating hospitals. Many physicians are still protective of their physician-patient relationship, and some discharge planning staff are reluctant to initiate post-hospital arrangements with patients without physicians' consent. The training and practice patterns of physicians do not always attune them to post-hospital needs or the need to make arrangements in advance for such care. Some discharge staffs have made efforts to educate medical staff about these issues with some success, but the training and information functions have not been formalized.

The hospitals have criteria for targeting assessment and planning for post-hospital care. High-risk groups are usually identified and given special attention. These include:

- Over age 80
- Cancer
- Stroke
- Hip fractures
- Live alone, no close relatives
- Patients readmitted within 14 days.

Severity of the patient's condition is not formally considered because such measures are not available at discharge. One hospital is trying to develop a system that would alert discharge planners to patient needs based on the severity of illness in the hospital.

Most discharge planning activities follow a similar pattern of identifying high-risk patients, reviewing cases either in rounds or conferences, conferring with home health staff on site to help arrange for home care, and talking with physicians, patients, and their families. Increasingly, skilled nursing assessments are needed because patients are going home with more medical needs now. Durable medical equipment often must be arranged as well.

The activities of discharge planners are similar across the hospitals, though they vary in intensity. For example, some discharge planning staff spend time trying to brief physicians on discharge planning and its importance while others have little contact with physicians. In one hospital many functions are carried out by the discharge planning/utilization review staff, including pre-admission screening and tests, counseling services, and coordination of post-hospital services. This continuity of care program was established in 1984 with the advent of PPS, and collects data on all inpatients except those admitted from the emergency room, not just Medicare.

Admissions screening provides the opportunity to assess post-hospital care needs very early in the episode. In theory, it should give nurses a key role in the patient's path into and out of the hospital, thus changing the physician-nurse relationship, but the staff still speak of "referrals" to discharge planning, stating that four-fifths are initiated by physicians. Thus, the physician still appears to play the dominant role in deciding who needs post-hospital care and when discharge planning should enter the picture.

Discharge planning units in the Albuquerque area do not do post-hospital case management for patients, but they do make efforts to follow up discharged patients to see if services ordered are being provided and to check progress. One hospital discharge planning unit requires each staff person to make follow-up phone calls to several high-risk patients within the month after discharge, and they follow up with adult protective service programs to assure that arrangements are made. Another hospital makes follow-up phone calls to about a third of the patients discharged to post-hospital care to assure that services are being delivered.

Discharge planning does not appear to have found a comfortable place or stature in the hospital's hierarchy or in the patient care process. Top level hospital administration, as well as physicians, have yet to utilize their potential fully, according to discharge planning staffs. Yet, one hospital discharge planner observes that "three years ago discharge planning was a luxury; now it is a necessity." The staffs receive increasing attention from community agencies and are expected to perform some case management functions. Some planners feel overburdened; others welcome the new challenges.

Hard-to-place patients are seen as a problem, for even though nursing homes can not afford to be too selective, they still avoid certain types of cases. Inability to pay remains a major obstacle to nursing home placement. Skilled Nursing Facility reimbursement from Medicare is all but impossible to obtain, according to all staffs. Nursing homes try to avoid heavy-care patients such as ventilator and tube-fed patients. Even though many patients spend down to Medicaid eligibility in nursing homes, facilities are reluctant to accept patients who don't already have either Medicaid coverage or substantial personal resources.

While post-hospital services are generally available in the Albuquerque area, they are lacking in the rural parts of the state to which many patients must return following hospitalization. Some rural hospitals are opening swing beds to address the problem. Also, since many of the patients in Albuquerque hospitals come from distant rural areas, discharge planning staff must keep abreast of what services are available in local areas in order to arrange for post-hospital care.

6.4 Home Health Agencies

There is a relatively small number of home health agencies (HHAs) in Albuquerque, particularly considering that some are very small. Two hospital-based agencies are extremely small, and one private agency had

only one Medicare patient at the time of the site visit. Two hospitals have owned a home health agency for many years, and two more have recently established very small agencies. One of these is considering a merger with an existing free-standing HHA to supplement its capacity.

The largest HHA is a hospital-based agency which is part of an umbrella home care organization that includes a hospice, a home infusion therapy company, and a durable medical equipment firm. This HHA in turn is part of a multifaceted system that includes complex organizational relationships at the hospital level. Another free-standing HHA has multiple arrangements with health maintenance organizations to care for their home care patients. This agency appears to be moving quickly to keep pace with the changes in the area, and its caseload is growing. Conversely, another free-standing HHA believes that it has lost patients partly because of the growth of HMOs in the area. This agency is considering merging with a hospital to stem its loss of patients. The problems of this agency reflect the increasingly competitive nature of the Albuquerque health care industry, both among hospitals and HMOs.

Health maintenance organizations are popular with the HHAs, even though they pay discounted rates. They are, by most accounts, much easier to work with than the Medicare Fiscal Intermediaries. They operate their home health benefit according to Medicare rules, but they are willing to grant prior approval for services, so the agency knows it will be paid for certain services rather than having to guess and risk denials. Further, HMOs do not require the staffing levels or "paperwork" required of the Medicare FI.

HMOs in turn have sought to use home health agencies as a substitute for higher levels of care in hospitals or emergency rooms. HHAs are often brought in to do emergency assessments in the home and to provide crisis services. This practice might prove useful in the future to physicians who do not wish to admit patients but who wish to obtain some services for them on an immediate basis.

6.4.1 Adaptations

As in other cities, virtually everyone feels that home care patients are sicker upon hospital discharge compared to the past. Increased intravenous procedures, total parenteral nutrition and physical therapy are noted by most as being on the increase. HMOs are said to be a particularly noticeable source of high tech and complex care patients. To cope with these patient care needs, HHAs have raised their skill requirements. They now are hiring nurses with intensive care unit experience and with greater skills at medical assessment, which are now considered critical in the home care field. Home health aides with more formal training and experience are now being sought to support more home-based nursing services. Finally, more physical therapists are needed for home health care, but supply is quite limited in New Mexico.

Complexity and acuteness of needed care are also cited as new trends. Multiple daily visits for a short period are provided more often. In addition to medical needs, there is an increased need for

personal care, homemaker and social support services. Patients who in the past would have remained in the hospital for more recovery are now being sent home.

6.4.2 Patient Care Problems

Patients often "fall through the cracks" according to HHAs, either because needed services are not in place prior to hospitalization or because funds are not available to help discharged patients pay for the personal care and support services they need in the short run. Medical problems may occur without adequate support and monitoring, or patients might not receive needed help in regaining functional capacity. Educating patients and families about post-hospital care is often lacking. Transportation home for those without personal support services is also needed. A free-standing HHA reports it no longer provides charity care to patients needing these services, and no longer accepts patients without a third-party payer.

HHAs note that while the level of illness and the post-hospital care needs of Medicare patients are rising, the actual number of visits provided to Medicare patients has decreased. One agency administrator says its average number of visits per patient has fallen to 17 per patient this year (the national average in 1984 was 26).

Patient access to needed services at the right time is seen as a problem, resulting partly from inadequate discharge planning efforts by hospitals. There seems to be agreement that hospitals still have a long way to go in putting together a coordinated and aggressive discharge planning activity. HMOs are cited as being better and more aggressive at discharge planning activities.

6.4.3 Administrative Problems

All of the HHAs directors interviewed state that the Fiscal Intermediaries have caused problems by tightening up on eligibility and coverage. A particular problem is the change in the definition of "homebound." Medicare patients are deemed to be homebound now only if they are unable to leave the home even for medical care. This has resulted in more claims denials. Directors also voice dissatisfaction about what they see as HCFA insisting on more information as part of the new plan of treatment forms. They say they are cutting back on visits due to fear of retroactive denials, even though the visits are ordered by physicians.

6.5 Nursing Homes

Nursing home beds are in adequate supply in the Albuquerque area, although occupancy rates vary among facilities, depending on reputation. One facility has a substantial waiting list while others usually have empty beds. In areas outside of Albuquerque, however, the nursing home bed supply is much more spotty, especially in rural areas.

As in other areas, Albuquerque nursing facilities, even if certified for Medicare, have very few Medicare patients. For example, a facility with 30 Medicare-certified beds has an average daily census of five or six Medicare patients, contrasted to 15, three years ago. This number had been falling since 1982, but stabilized in 1985. The number of Medicare patients now appears to be rising slightly. Most nursing home patients are either on Medicaid or are paying for their care out-of-pocket.

The main reason for the drop in the Medicare census given by nursing home administrators is that the Fiscal Intermediary tightened its medical necessity and skilled care determinations in response to what are considered HCFA directives. Physical therapy, according to them, has been all but eliminated. Retroactive claims denials subsequently became a serious problem and deterred nursing homes from admitting patients in the expectation of receiving Medicare reimbursement. A higher risk of denial, therefore, may have inadvertantly restricted access.

Nursing home administrators note changes over time in the nature and severity of illness of patients; they are much sicker now, whether they come from the hospital or the community. More patients are admitted for short, episodic treatment and rehabilitation now and fewer for long-term care. One facility has reportedly seen such an increase in the skilled nursing facility (SNF) level of need that it now resembles an acute hospital medical floor. Similarly, the intermediate care facility (ICF) level of care has increased as long-term patients grow sicker over time and because patients are admitted in a more debilitated condition than in the past.

Intravenous therapies and total parenteral nutrition (TPN) are new services in one facility, and they apparently create reimbursement problems. On the one hand, the Medicare FI often rules that these cases do not fit their skilled care or other criteria and will not pay for them. On the other hand, the Medicaid program has been denying claims for this care on the grounds that these are acute services and should be provided in the hospital.

Nursing homes directors cite some instances of readmission to hospitals because patients are not stabilized when they arrive at the nursing home. Cardiac patients are said to be particularly vulnerable. The facilities also have admitted patients who were reportedly discharged home from the hospital but who needed too much care to stay there. One facility has refused to admit some patients discharged from the hospital because they were too sick and were discharged too soon. Examples given include a patient transferred from the hospital with a 104^{o} fever, and another needing suction procedures every 20 minutes.

Increased financial burden on patients and families is also seen as a problem. Care previously covered in the hospital must often be paid for by the patient in the nursing home.

A mechanism for coordinating and managing the appropriate levels and timing of care is increasingly necessary as earlier discharges become more frequent. Relations between nursing facilities and hospital discharge planners are marred by some mutual suspicion because motives

are often conflicting. The hospital wants to discharge patients while the nursing home wants to limit the number of difficult patients it accepts. Discharge planners are seen as being more frank and open as they must work with families and nursing homes to place sicker patients. Increased nursing staff involvement in the discharge planning process is also seen as a plus.

7.0 PROGRAM OPERATIONS

7.1 Peer Review Organization (PRO)

7.1.1 Administration and Organization

The New Mexico Medical Review Association (NMMRA) had been the PSRO and then the PRO for New Mexico. As of October, 1986, there had not been an official New Mexico PRO since the end of July. NMMRA had been in contract negotiations with HCFA for several months. If it did not win the Medicare contract it would lose their Medicaid contract for the state as well. Although most of its work is for the public sector, NMMRA does have some review contracts in the private sector including local unions and insurance companies. Some of the problems that HCFA had with NMMRA were their low denial rates and lack of any physician sanctions.

7.1.2 Review Process

NMMRA receives hospitals' claims tapes from the FI every week and at the end of each month enters the tapes for that month into the system. Cases are then selected for review. Records are selected based on HCFA quality of care computer screens, DRG validation, and admission validation. About 60 percent of all reviews are done on site. The remaining hospitals mail their records to NMMRA. All hospitals have 14 days to provide the record.

All reviewers are registered nurses. These nurses complete review worksheets either on-site or at the PRO. On site, if the reviewer has a problem with the record that cannot be resolved (e.g., the patient did not meet acute care criteria), the facility copies the record for the reviewer to bring back to the PRO. A physician consultant then reviews the record and makes the final decision.

Once a claim is denied, the nurse reviewer notifies the attending physician. The attending physician then has the opportunity to respond to the denial by contacting the medical director at the PRO. If there still is a dispute, another physician is consulted. Once denial letters are sent out, there are still 60 days for either the hospital or attending physician to ask for a reconsideration. The correction claims tape is returned to the Fiscal Intermediary.

There are four types of PRO reviews. The first is the preadmission review, a requirement for specific kinds of cases. The attending physician contacts a reviewer at the PRO and the case must fulfill certain criteria before being given preadmission approval. All readmissions within 15 days and a random sample of claims for DRG validation are two other types of cases that are selected for review by the computer. NMMRA also does concurrent reviews for cases with particular diagnoses. For example, decubitous ulcers are reviewed concurrently, to determine if treatment is aggressive enough to warrant level 1 acute hospitalization.

NMMRA tracks the productivity of its reviewers through quarterly reports. The number of reviews performed per day is recorded, and in

addition, a five percent sample of reviewers' records are rereviewed as a quality check. When NMMRA lost its PRO contract, the staff went from 44 to 20 people.

NMMRA had problems meeting its objectives during the first contract year, -- particularly its low denial rate. Most hospitals had a denial rate of less than 1/2 percent. In the beginning of the contract, preadmission denial rates were higher, but as physicians became familiar with the criteria, these denials were reduced. New Mexico has had a history of active PSROs and strong controls on utilization. Length of stay had been declining since the late seventies. This PRO complains that the reason their denial rates are so low is that providers and physicians were already well educated by the PSROs to keep utilization of services and costs to a minimum, and there was not as much "fat to trim" in New Mexico as in other states. The PRO wanted to have a deterrent effect rather than denying claims outright.

Maintaining that utilization was already low in Albuquerque before PPS, however, can not explain the fact that hospital admissions are down 10-20 percent and total inpatient days have fallen 15-35 percent. Hospitals have obviously responded to the program's incentives. How important the PRO was in lowering use rates is unclear.

7.1.3 Changes Since PPS

NMMRA has heard complaints from nursing homes that patients have been discharged "quicker and sicker." However, PRO staff do not believe this is a significant problem. It is NMMRA's administration's opinion that lengths of stay have been dropping due to more efficient use of hospital services. It is not concerned about quality of care issues, although staff mention that there has been an increase in the number of reviewed claims being referred to physician consultants due to quality screens.

Staff at the PRO have differing opinions on the level of services in the community. The director thinks that there are adequate numbers of nursing home beds available, while others feel that there is a shortage of beds, particularly in rural areas. This is consistent with nursing home directors responses that emphasize the scarcity of beds in rural areas but not necessarily in Albuquerque.

NMMRA has examined transfers and readmissions for appropriateness. It has not found any transfers to be inappropriate and staff do not think readmissions have been caused by poor quality of care during the first admission. Most transfers are cases where patients were transferred to a provider closer to their homes and families. The new emphasis on avoiding planned readmissions has taken place after NMMRA's contract lapsed, although they made an effort to warn hospitals about it.

NMMRA also monitors letters that hospital U/R coordinators have sent to patients when acute inpatient care is no longer necessary and patients become liable for out-of-pocket expenses. NMMRA has done retrospective reviews on a sampling of hospital-terminated acute stays. NMMRA has seen very few unjustified denials or social admissions, although they are prevalent in Indian Hospitals in New Mexico not covered by Medicare.

7.1.4 Provider Interaction

NMMRA staff believe they have a good relationship with providers. They communicate through both letters and phone calls. Letters are always sent to providers before going on site or when requesting records to be sent. Most of NMMRA's contact with hospitals is with medical records directors. However, reviewers always make an effort to meet with administrators of hospitals when on site, for educational purposes. They feel they are more successful with smaller hospitals. Also, every month NMMRA meets with the hospital association. In addition, there are two hospital administrators who participate as consultants at NMMRA's board meetings.

When the site team visited NMMRA, it had not been the New Mexico PRO for over three months. Hospitals were worried about the backlog of reviews to be done. In particular, hospital directors were worried that because preadmission review had been in abeyance for so long, numerous denials would occur once cases were reviewed. NMMRA is sensitive to these concerns and has spent time preparing for contract renewal. It has planned three workshops for provider education and has changed some old policies to improve relations. For example, one problem was that the old medical director telephoned the attending physician if a case was denied but did not document the call. The physician had three days to request a rereview, but some physicians claimed they never received the call. For the new contract, if won, letters will be sent to the physicians to document these phone calls.

7.2 Fiscal Intermediary

7.2.1 Claims Processing

Blue Cross and Blue Shield of New Mexico (BCBS) is the Medicare Fiscal Intermediary (FI) for this state. BCBS receives claims both electronically and in hard copy form from providers. The claims are put through front-end edits which immediately reject claims for inconsistencies or incompleteness. Claims that do not pass the edits are returned to the provider before entering the system. Once in the processing system, the claims are checked to determine eligibility and then "batch" edits are done on the claims. These edits include identifying claims requiring prepayment approval by the PRO or claims requiring medical review by BCBS. Reviewed claims are either put back into the system for payment, allowed partial payment, or determined ineligible for payment. Denial letters are automatically issued to providers for ineligible claims. Eligible claims are processed and payments are made to the hospitals once a week. An "unbill" tape of all the inpatient claims is then sent to the PRO.

Claims are returned to the provider most commonly for technical reasons. These reasons include incomplete identification, unsigned claims, no HSI number on the claims and charges that do not total correctly. Obtaining correct documentation on the claims is a definite problem for this FI. In fact, most denials are for technical reasons.

7.2.2 Review Process

The medical review department at BCBS is responsible for all reviews performed on outpatient, SNF, home health, ESRD (End Stage Renal Disease), and hospice claims. The first level of review is a computer screen in the batch edits during claims processing. The second level of review is the nurse reviewer who may approve claims but can deny them only on the basis of documentation problems. The third level of review is the physician consultant who examines the unresolved claims and approves them or recommends a denial.

In the outpatient setting, physical therapy patients generate the most denials, usually because of poor documentation. Home health agencies (HHAs) have a denial rate of 12.9 percent. One third of the HHA denials are due to issues of medical necessity and the rest are inappropriate documentation. Medical necessity denials are most often due to overutilization of services, particularly nurse visits.

BCBS is having some problems with the 485-488 forms for HHAs. They are under instruction to make approval or denial decisions based on these forms, but they often need to request records for further information. The number of HHAs on waiver of liability has dropped 20 percent since PPS, from 47 to 34 agencies. Six of the ten SNFs are now off the waiver as well. BCBS is not sure that the loss of waiver status since PPS has been a result of PPS.

The New Mexico FI defines skilled care as daily skilled nursing, five times a week, including rehabilitation by a physical therapist. Intermittent care is skilled nursing visits three or four times a week. The homebound requirement specifies that the patient must be unable to leave the home and receive the medical care she needs in an outside setting. If the patient is able to go to a physician's office, she is not considered homebound. For years there had been no emphasis on the appropriateness of HHA claims. Under PPS, all claims are questioned. This has caused some hostility between this FI and providers.

It is the opinion of this FI's staff that patients are definitely being discharged from hospitals needing a higher level of care than in the past. There have been more daily care patients and an overall increase in the utilization of HHAs. The number of HHAs in New Mexico has increased from eight in 1980 to 47 at the present time. Intravenous therapy and alcohol detoxication are examples of two treatments that had previously been done in the hospital but are now being done in the home. According to BCBS, some patients are being discharged from hospitals with acute level care needs and placed in SNFs. Also, in some parts of the state, patients are treated in the home when their conditions are intense enough to place them in a SNF or ICF. BCBS is concerned about their welfare, particularly those patients in the home who require 24-hour care that the families cannot provide.

7.2.3 Relations with Providers

Relations with providers have been good since PPS. In general, hospitals have been doing fairly well in New Mexico, except for those

located in certain rural communities. Providers are notified of payment rates by letter. BCBS makes an effort to inform providers well in advance of a change in rates, but BCBS often does not receive instructions from HCFA until immediately before or even after the change. Hospitals are given a computerized ID sheet that specifies the payment rates, including any adjustments and the Gramm-Rudman one percent reduction. Providers also receive regular newsletters providing useful information. For example, one newsletter gave instructions on the proper documentation requirements on HHA claims forms.

BCBS has not received many complaints from hospitals regarding payment rates. Some complaints have been received in response to the Gramm-Rudman cuts. A few hospitals that have elected to keep sole community hospital status have also complained because they would do better without this status. Presumably, they are not willing to take the risk of "going onto PPS" for the extra payment.

7.2.4 CPEP and PIP

The New Mexico FI staff considers itself "middle of the road" with respect to the CPEP scores. Last year the FI did not do too well in its reimbursement levels. This year it has added a reimbursement department to remedy this problem. Another problem is the mandated five-to-one savings ratio requirement on Medicare cost report audits. Since PPS, BCBS has been having a hard time making this ratio. Inpatient review is not done by the FI anymore. It can only adjust on outpatient services and it is difficult to get savings there. BCBS feels that this five-to-one ratio is an unrealistic standard to meet.

The elimination of PIP will have only a minimal effect on providers in New Mexico. Only 21 hospitals and 5 HHAs were on PIP. (HHAs are not required to go off PIP.) However, BCBS is glad to be eliminating PIP because of the amount of time it will save. Payments are already fast enough so that several new HHAs have opted out of PIP.

The Gramm-Rudman cut imposed a one percent reduction of providers' total reimbursement from Medicare. In New Mexico each provider gets shown the amount of the reductions on its weekly check, a practice the FI feels is having a large impact on providers.

7.2.5 HCFA Relations

HCFA communicates with BCBS through phone calls, followed up by letters. Most of this communication is done through the Dallas regional office, which is very good about expressing the issues to BCBS. However, there have been problems with directives received from the central office. BCBS's biggest complaint is that rate changes are often made without prior notice and they then have to make retroactive changes. For example, BCBS did not receive instructions on the May 1, 1986, rule changes until May 6. The instructions were to be implemented immediately. After the rates had been implemented, HCFA notified BCBS that those instructions were wrong and BCBS had to correct payment rates

to 100 hospitals. Another problem with HCFA resulted in delays in claims processing. A HCFA edit module incorrectly kicked out 100 percent of the 485-486 HHA claims. This resulted in a month delay in processing the claims.

When faced with Federal budget cuts, the New Mexico FI cuts back on certain services and tries to streamline operations. Fewer field audits are done and training is cut back. Providers are encouraged to use electronic billing. Efforts are made to decrease time on computers.

CMS LIBRARY
3 8095 00013565 3